

FOR STATE
HEALTH DEPT.

12463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12472

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>142 N. Main St.</u>		d. STREET ADDRESS <u>N. Main St</u>	
3. NAME OF DECEASED (Type or print) <u>Theodore Archer Jr.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/1905</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	
11. BIRTHPLACE (State or foreign country) <u>Bel Air, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Archer Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Bessie E. Wann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-8162</u>	
17. INFORMANT <u>Theodore Archer Sr.</u>		Address <u>RD #2 Box 143 White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		2161 INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>9-14-67</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>9/17/1967</u>	<u>Bethel</u>	<u>Madonna, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If duty delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1003

(1)

Commercial

Theodore Arthur

217-01-1152 Theodore Arthur
RD #2 Box 147
White Hall, Md.

2181

20/1/1967

Charles A. Jones

2182

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

199

MEDICAL CERTIFICATION

2

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12473

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>BERKS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>1129 Chestnut St</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Eric Bagenstose</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 1, 1920</u>
9. AGE (In years last birthday) yrs. <u>47</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	
11. BIRTHPLACE (State or foreign country) <u>Reading Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANCIS BAGENSTOSE</u>		14. MOTHER'S MAIDEN NAME <u>EDNA FREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>202-07-0027</u>	
17. INFORMANT <u>Mrs Bagenstose</u>		Address <u>Reading Pa</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV Disease</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lereld C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>9/4/1967</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Springtown Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Springtown, BERKS CO Pa</u>	
24. FUNERAL DIRECTOR <u>Carrington & Son</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 6 1967</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

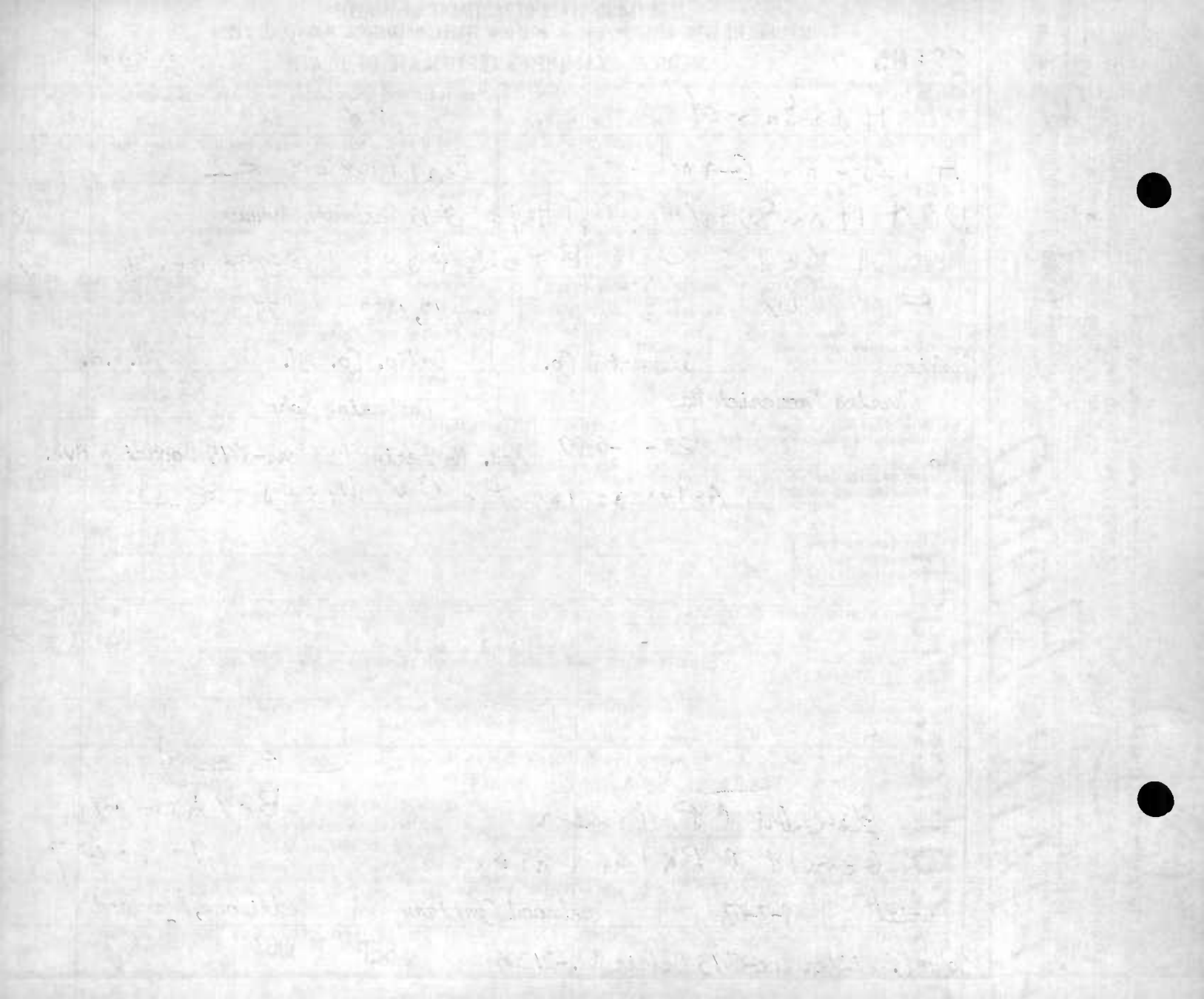
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12465

12474

1. PLACE OF DEATH a. COUNTY <u>Harris</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harris Grace</u>		c. LENGTH OF STAY IN lb <u>_____</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harris-Sord Memorial Hsp</u>		d. STREET ADDRESS <u>3433 Parklawn Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Anna C. Brodka</u>		4. DATE OF DEATH <u>September 4 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1892</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stewart & Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Frederick Rau</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Sohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-6990</u>	
17. INFORMANT <u>Mrs. Katherine Badders</u>		Address <u>3419 Woodring Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 4221 DUE TO _____ (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-4-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) <u>Baltimore, Maryland</u> (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>John C. Miller Inc</u>		ADDRESS <u>6415 Belair Rd. -21206</u>	
25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

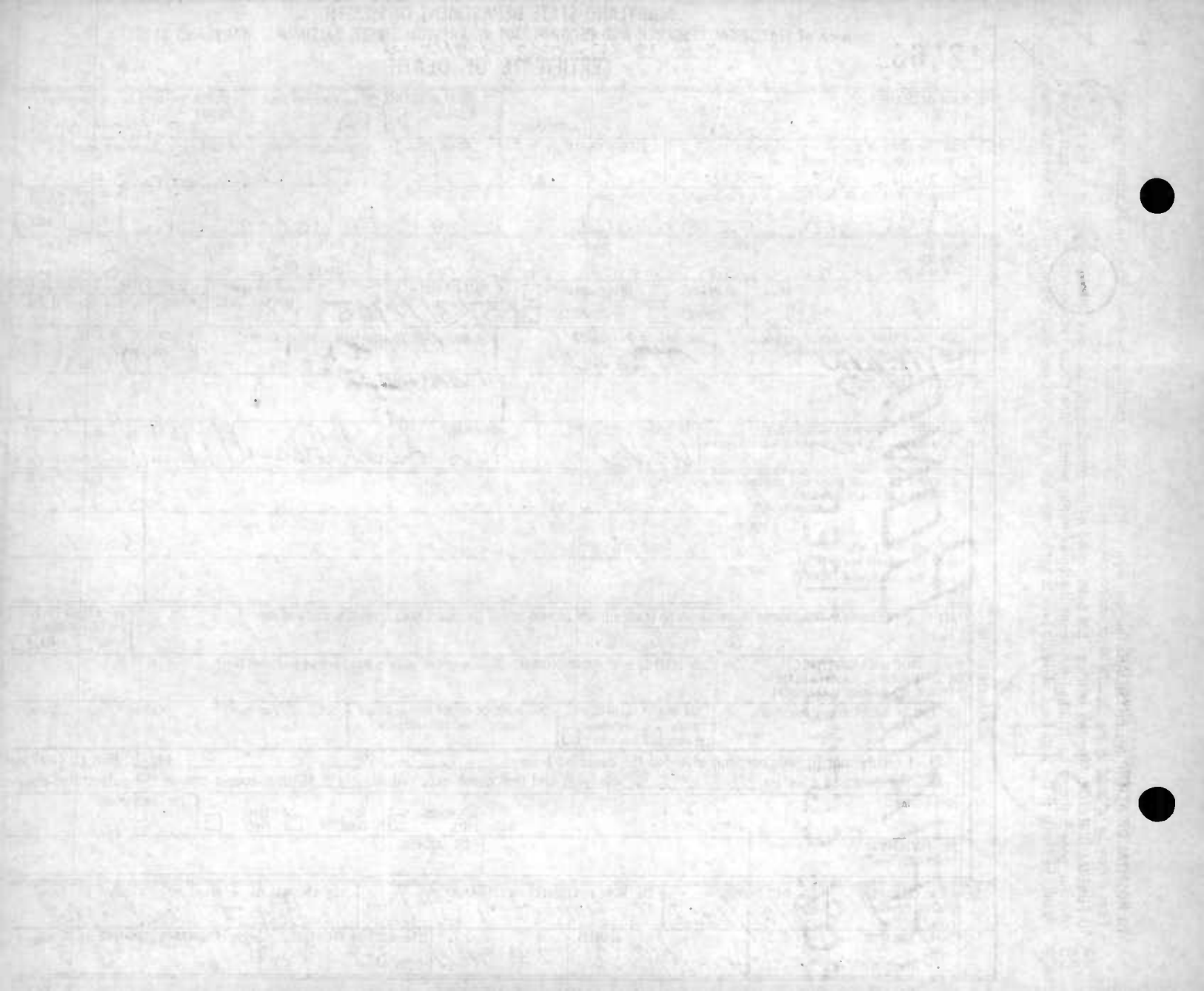
12466

Item 12 Film 2393 9/29/67 HK

CERTIFICATE OF DEATH

12475

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN lb <u>12 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		d. STREET ADDRESS <u>207 Alliance St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Constantino</u> Middle <u>Budano</u> Last <u>Budano</u>		4. DATE OF DEATH <u>62</u> 9 18 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/31/1905</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mason</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Mrs. Sarah Creswell</u>		Address <u>207 Alliance St. Harre de Grace, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hepatic failure</u> DUE TO <u>5810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cirrhosis of liver</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5+ yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-6-67</u> , 19 <u>67</u> to <u>9-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-18-67</u> , 19 <u>67</u> , and that death occurred at <u>848</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>S. J. Plunkett Jr</u>		22b. DATE SIGNED <u>9-18-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u>		23d. LOCATION (City or town) (County) (State) <u>North East Cecil MD</u>	
24. FUNERAL DIRECTOR <u>Pennington & Son, Harre de Grace, MD</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

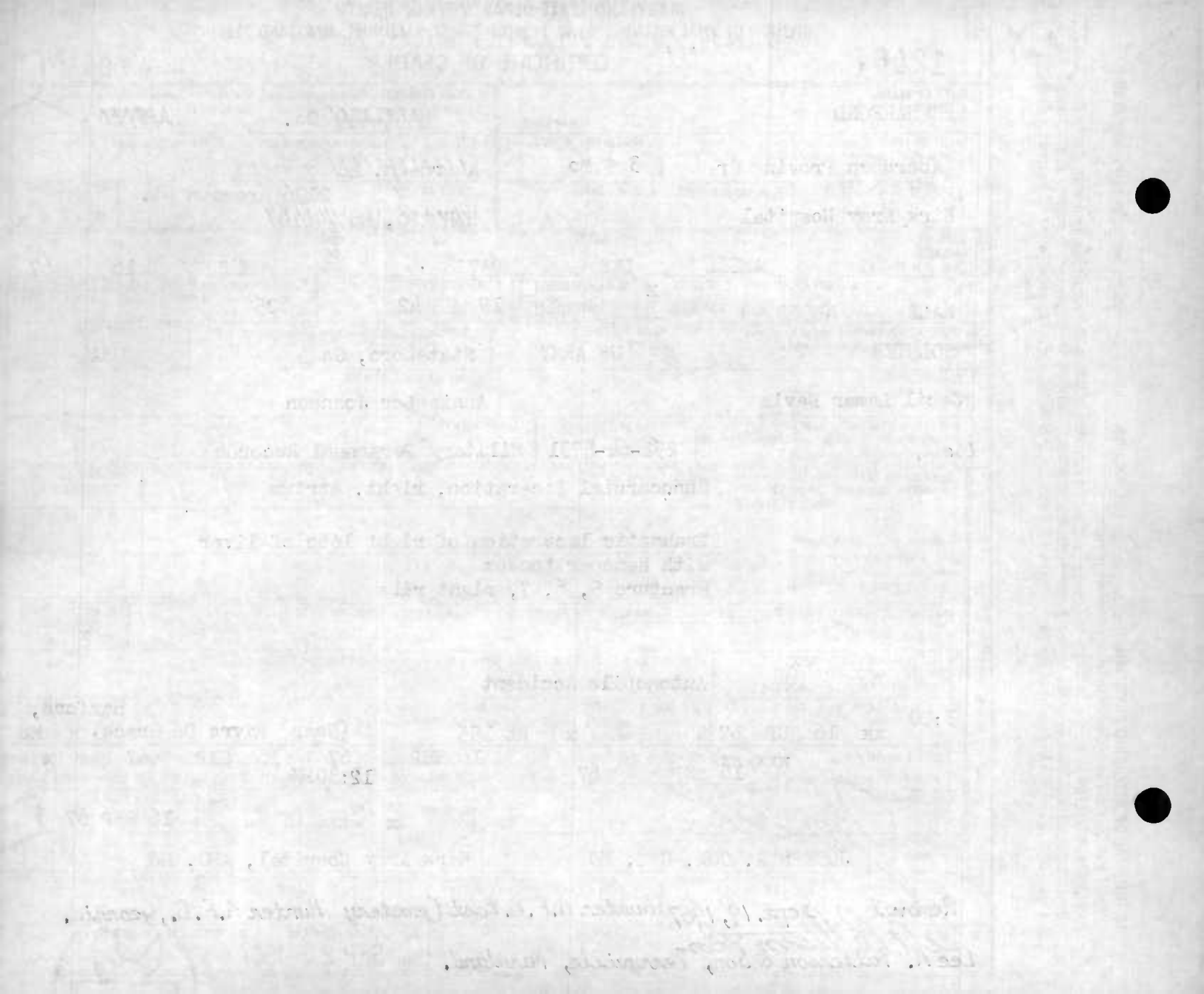
Item #2a, b, c & d Film #5593 10/4/67 ph

12467

CERTIFICATE OF DEATH

12476

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND Ga. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Gr		c. LENGTH OF STAY IN lb 3 1/2 Mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Md / Savannah		d. STREET ADDRESS 2136 Krenson St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL LEE DAVIS		4. DATE OF DEATH Month Day Year SEP 16 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 FEB 42
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY US ARMY	
11. BIRTHPLACE (County & State, or foreign country) Stateboro, Ga		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cecil Lamar Davis		14. MOTHER'S MAIDEN NAME Annie Lou Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 252-64-4731	
17. INFORMANT Military Personnel Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endocardial laceration, right, atrium DUE TO (b) Traumatic laceration of right lobe of liver DUE TO (c) with hemoperitoneum Fracture 5, 6, 7, right ribs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year 3:00 a.m. 16 SEP 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 155	20f. (City or town) (County) (State) (Near) Havre De Grace, Md
21. I certify that (I) (this hospital) attended the deceased from 16 SEP 19 67 to 16 SEP 19 67 , that (I) (we) last saw the deceased alive on 16 SEP 19 67 , and that death occurred at 12:30 AM from causes and on the date stated above.			
22a. SIGNATURE Joseph A. Cox		22b. DATE SIGNED 16 SEP 67	
22c. PHYSICIAN'S NAME (Type) JOSEPH A. COX, CPT, MC		22d. ADDRESS Kirk Army Hospital, APG, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Sept. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hunter A.F.B. Post Cemetery		23d. LOCATION (City or Town) (County) (State) Hunter A.F.B., Georgia	
24. FUNERAL DIRECTOR Lee A. Patterson & Son		25a. REC'D BY REGISTRAR SEP 26 1967	
ADDRESS Perryville, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

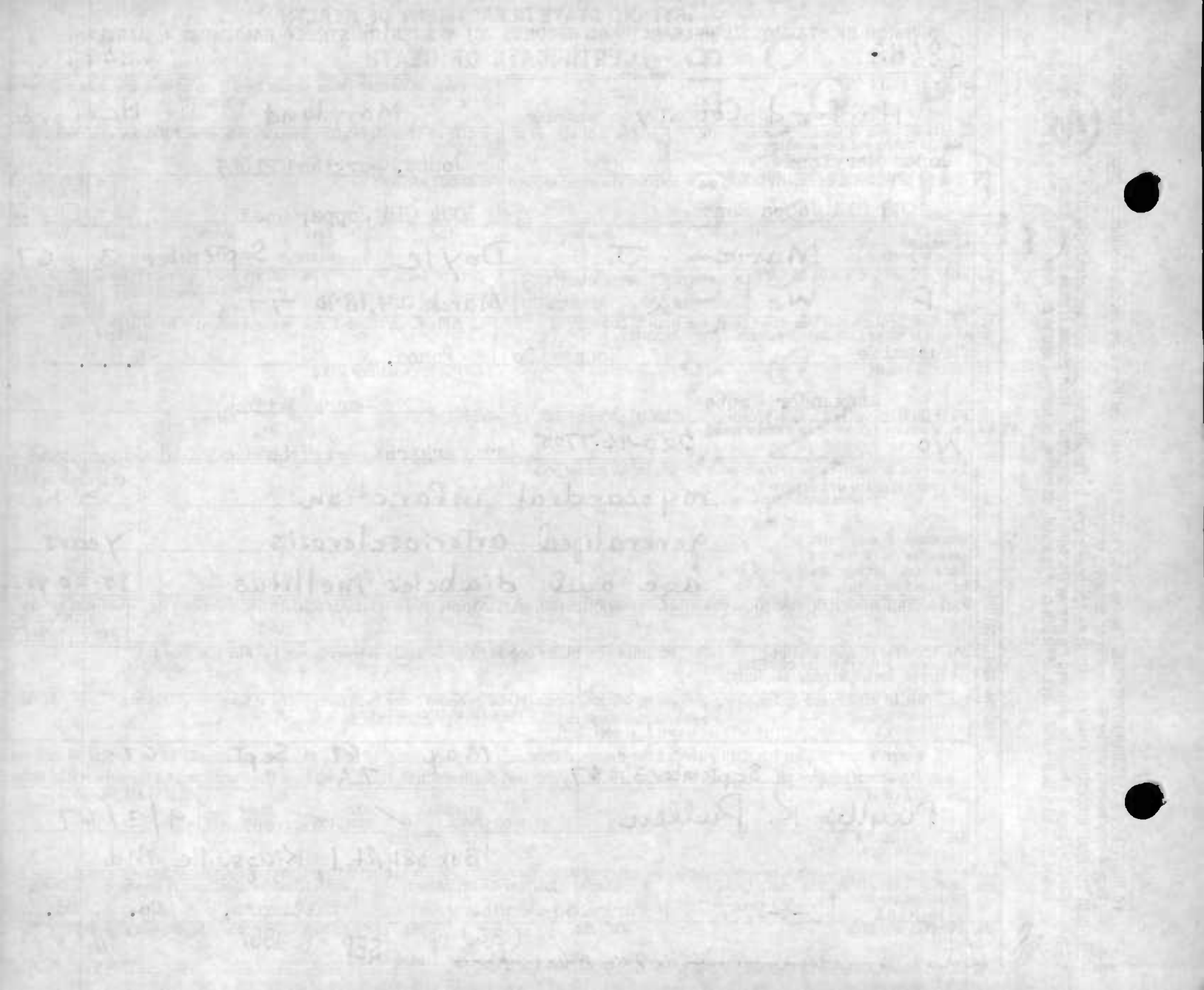


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12468					12477				
1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa Maryland</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Maryland 21085</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1004 Old Joppa Road</u>					d. STREET ADDRESS <u>1004 Old Joppa, Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie J. Doyle</u>					4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1894</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Alexander Watts</u>				14. MOTHER'S MAIDEN NAME <u>Laura Deiter</u>					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-46-7705</u>		17. INFORMANT <u>Mrs Margaret DeVaughn 1004 Old Joppa Road</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>age and diabetes mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>Years</u> <u>15-20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 3</u> 19 <u>67</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Phyllis K. Pullen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/3/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Phyllis K. Pullen</u>				22d. ADDRESS <u>Box 381, Rt. 1, Kingsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>				ADDRESS <u>(36)</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

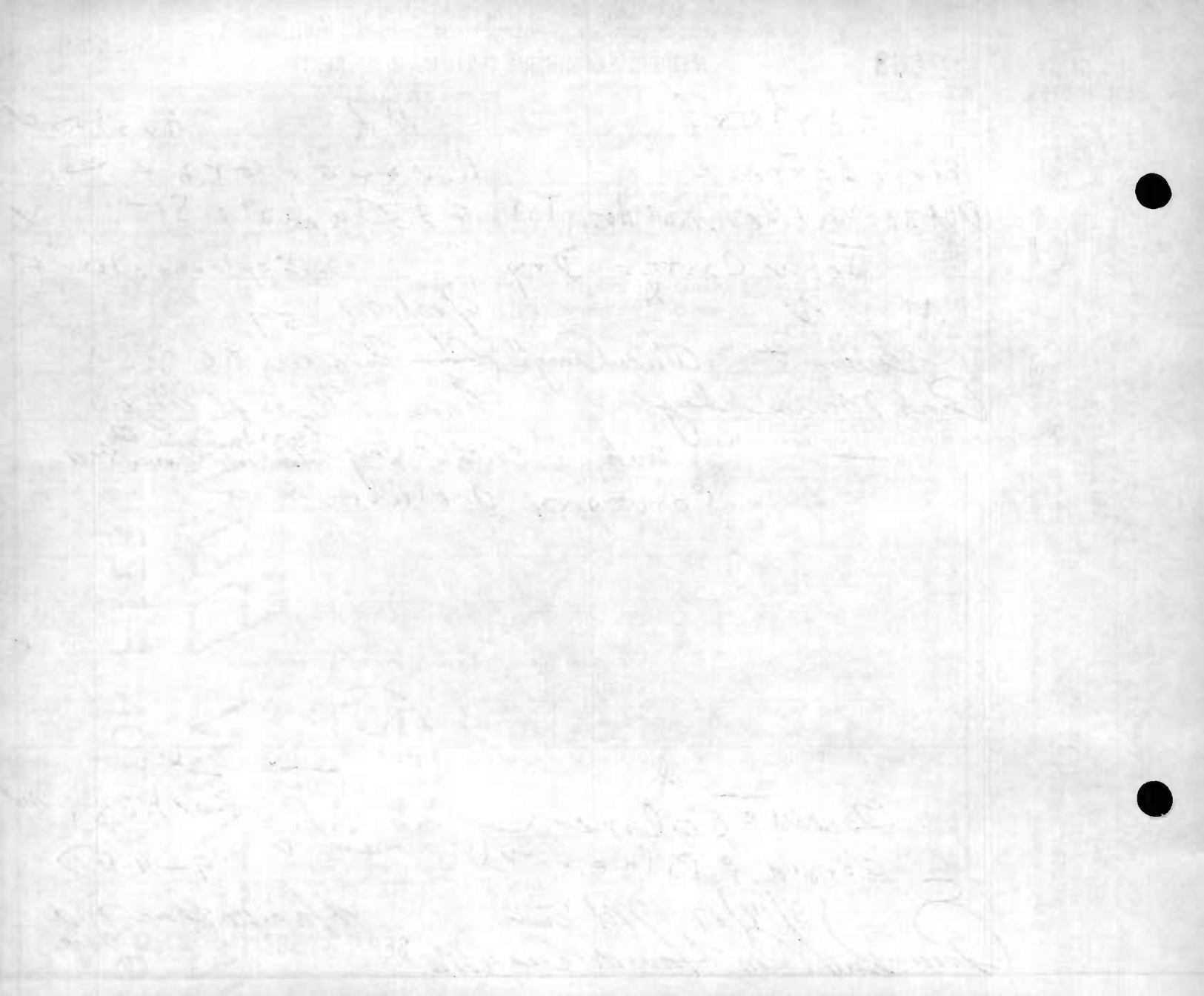
12469

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurrode Grace</u>				c. LENGTH OF STAY IN 1b <u>533 Juniors St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dothan Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Carter Dry</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/1910</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Chadron, Nebraska, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Monroe Dry</u>				14. MOTHER'S MAIDEN NAME <u>Thomas Elizabeth Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>+</u>				16. SOCIAL SECURITY NO. <u>umb.</u>			
17. INFORMANT <u>Edith B. Dry</u>				Address <u>533 Juniors St, Hartford, Conn.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>9-11-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Erin</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>Luncheon, Rm. Harold Chase, Md.</u>				25. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



12470

CERTIFICATE OF DEATH

12479

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) General Delivery		d. STREET ADDRESS General Delivery	
3. NAME OF DECEASED (Type or print) Margaret J. Duffy		4. DATE OF DEATH Month September Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1884
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 12 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Nelson (D)		14. MOTHER'S MAIDEN NAME Cecelia T. Cummings (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Joseph H. Nelson, Perryman, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma buccal mucosa DUE TO (b) 144X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) hypertensive arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypertensive arteriosclerotic cardiovascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1 , 19 65 , to Sept 13-67 , 19 67 , that (I) (we) last saw the deceased alive on Aug 11 , 19 67 and that death occurred at 11:00 AM , from causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett Jr.		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D.		22d. ADDRESS Aberdeen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15 Sep. 67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Walter McCoubie Jr.		25a. REC'D BY REGISTRAR Tarring Funeral Home	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 18 1967	

October 1944

Ergebnisse der Untersuchungen

15-11-11 11:11

2-14-9

[Faint handwritten notes at the bottom of the page]

12471

CERTIFICATE OF DEATH

12480

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>301 Fountain Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>A.</u> Last <u>Ferguson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1882</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Chatham, Penna.</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-48-7283</u>	17. INFORMANT <u>PO Box 684 address Balboa Camel Zone</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO (b) <u>Coronary heart failure, decompensated</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL/CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harbview</u>	23d. LOCATION (City or Town) (County) (State) <u>Coatesville Pa</u>
24. FUNERAL DIRECTOR <u>Cunningham & Son</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1932

1

DEATH RECORD

1. Name of Deceased: [illegible]
2. Date of Death: [illegible]
3. Place of Death: [illegible]
4. Cause of Death: [illegible]
5. Age at Death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Marital Status: [illegible]
9. Occupation: [illegible]
10. Signature of Registrar: [illegible]
11. Date of Registration: [illegible]

12472

CERTIFICATE OF DEATH

12481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>three-de-grace</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine Ann Fish</u>		d. STREET ADDRESS <u>1082-2nd ST</u>	
5. SEX <u>Female</u>		4. DATE OF DEATH <u>Sept 6 1967</u>	
6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>May 13, 1928</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>39</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Dimeo</u>		14. MOTHER'S MAIDEN NAME <u>Rose Laycona</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>Mr. Paul R Fish</u>		Address <u>1082 2nd St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>67</u> , to <u>9-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-6</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Paul R Fish</u>		22b. DATE SIGNED <u>9-6-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept 7/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Garden</u>		23d. LOCATION (City or Town) (County) (State) <u>Harford, Md</u>	
24. FUNERAL DIRECTOR <u>Genungton + Son, Harford, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12473

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12482

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS P.O. Box 715			
3. NAME OF DECEASED (Type or print) First FOUNT Middle L. Last HAINES Sr.				4. DATE OF DEATH Month September Day 1 Year 19 67			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 Jan. 1915	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Whse. Gen. Foreman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Lock Haven, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse B. Haines (D)				14. MOTHER'S MAIDEN NAME Mary Salmon (D)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes No		16. SOCIAL SECURITY NO. 162-12-4315		17. INFORMANT F.L. Haines Jr. Havre de Grace, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CV Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C. Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 Sep. 67		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, Maryland	
24. FUNERAL DIRECTOR John G. Tarring				ADDRESS Tarring Funeral Home		25a. REC'D BY REGISTRAR SEP 6 1967	
						25b. REGISTRAR'S SIGNATURE J. Haines Jr.	

21.

12474

CERTIFICATE OF DEATH

12483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Three-de-Grace</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>Perryman</i> <i>Box 79.</i>	
3. NAME OF DECEASED (Type or print) <i>Lillian Irene Hall</i>		4. DATE OF DEATH Month <i>9</i> Day <i>17</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15, 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lloyd Scornion</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Jasco</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-0037</i>	
17. INFORMANT <i>Mr. William L. Hall, Perryman Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i> <i>Acute coronary thrombosis</i> DUE TO (b) <i>arteriosclerosis card. vasc. dis.</i> DUE TO (c) <i>Diabetic mell.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>9-11, 1967</i> to <i>9-17, 1967</i> , that (I) (we) last saw the deceased alive on <i>9-17, 1967</i> , and that death occurred at <i>5:30 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept. 21, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary U.A.M.E.C.</i>	23d. LOCATION (City or Town) (County) (State) <i>Abertown Harford Md.</i>
24. FUNERAL DIRECTOR <i>O. J. Bullard, Harford Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 25 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12475

CERTIFICATE OF DEATH

12484

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Hickman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28/1967</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u>40</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, part or full time) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Dennis Hickman</u> Address <u>Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>761.5</u> IMMEDIATE CAUSE (a) <u>Prematurity.</u> DUE TO (b) <u>poor separation of the placenta.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>67</u> , to <u>9-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-4</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lajos Mezei, M.D.</u>		22d. ADDRESS <u>Harre de Grace Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/5/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>
24. FUNERAL DIRECTOR <u>See J. Patterson & Son, Pymouth, Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>SEP 6 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12485									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cardiff				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Forest Hill 12-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earl Middle C. Last Hinegardner			4. DATE OF DEATH Month Sept. Day 15 Year 19 67						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 17, 1887		9. AGE (in years last birthday) 80 yrs.		10. FUNDER 1 YEAR Months 12 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Greenbrier Co., W.Va.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Hinegardner					14. MOTHER'S MAIDEN NAME Emma ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 233-16-7134		17. INFORMANT Address Mrs. Kenneth Cantler, Cardiff, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seminoma of testis 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JULY 30, 1948 , to SEP. 15, 1967 , that (I) (we) last saw the deceased alive on SEPT. 13, 1967 , and that death occurred at 9:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Robert Barthel					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 16/67		
22c. PHYSICIAN'S NAME (Type) Robert Barthel					22d. ADDRESS Forest Hill, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Slateville		23d. LOCATION (City, town or county) (State) Delta, York Co., Pa.		
24. FUNERAL DIRECTOR John H. Harkins					ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR SEP 21 1967 DATE		
					25b. REGISTRAR'S SIGNATURE James Judge				

Wm. B. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

Joseph William Foster

12477

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12486

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hydes		c. LENGTH OF STAY IN b 45 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hydes	
d. NAME OF HOSPITAL OR INSTITUTION (Address) Reckord Road			d. STREET ADDRESS RFD #1, Box #66-A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ella Agnes Hogan			4. DATE OF DEATH Month September Day 14 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1909	9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Miller			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ----			14. MOTHER'S MAIDEN NAME Mary MacGilley		
16. SOCIAL SECURITY NO. 213-36-7847		17. INFORMANT (Son) 592-7102 RFD #1, Box #66-A Mr. John H. Hogan, Hydes, Md. 21082			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 7 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 66 , to 9/14 , 19 67 , that (I) (we) lost saw the deceased alive on 8/12/1967 , and that death occurred at 9:25 P.M. from causes and on the date stated above.					
22a. SIGNATURE Kermit P. Bonovich			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 15, 1967
22c. PHYSICIAN'S NAME (Type) Kermit P. Bonovich, M.D.			22d. ADDRESS Fallston, Maryland 21047		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal Cem.	23d. LOCATION (City or Town) (County) (State) Kingsville, Balto. Co., Md.		
24. FUNERAL DIRECTOR W. Broadway & Williams St. Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

Barford

Barford

Barford

Barford - 1955

Barford - 1955

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Barford Road

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Barford Hill, 1955

Barford Hill, 1955

Barford Hill, 1955

12478

CERTIFICATE OF DEATH

12487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>121</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>66 HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>717 Union Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Louise James</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	9. AGE (In years last birthday) <u>73</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Charlottesville, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Cain</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-20-4554</u>	
17. INFORMANT <u>Mrs. James James</u>		Address <u>Haverde Grace, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal Insufficiency</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>(a) Arteriosclerotic Heart Disease (b) Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1967</u> , to <u>Sept 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 29, 1967</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Haverde Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Charlottesville Harford, Md.</u>
24. FUNERAL DIRECTOR <u>Otelia J. Bullock</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 1967</u>	
ADDRESS <u>Haverde Grace, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15052

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12478

CERTIFICATE OF DEATH

12488

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b Aberdeen		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 404 S. Philadelphia Blvd.		d. STREET ADDRESS 404 S. Phila. Blvd.	
3. NAME OF DECEASED (Type or print) First EVA Middle RUTH Last KILBY		4. DATE OF DEATH Month September Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Dec. 1874
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Ashe County, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wiley W. Osborne (D)		14. MOTHER'S MAIDEN NAME Jane Mink (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-42-2000	
17. INFORMANT A. Lola K. Sewall , Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4330 DUE TO CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCUS (c) ASCUS		INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MYELONEPHRITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL 1967 to 9-14 , 19 67 that (I) (we) last saw the deceased alive on 9-13 , 19 67 , and that death occurred at 5:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Santiago Leyte-Vidal		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal M.D.		22d. ADDRESS Aberdeen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 16 Sep. 67	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Walter Macomber Jr.		25a. REC'D BY REGISTRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Form with multiple sections and fields, including a large circular stamp in the center. The text is mostly illegible due to blurriness and bleed-through from the reverse side. Visible fragments include:

- Top left: "RECEIVED"
- Top center: "OFFICE OF THE SECRETARY"
- Top right: "WASHINGTON, D.C."
- Center: Large circular stamp with text around the perimeter, possibly "U.S. DEPARTMENT OF AGRICULTURE".
- Bottom left: "RECEIVED"
- Bottom center: "OFFICE OF THE SECRETARY"
- Bottom right: "WASHINGTON, D.C."

Vertical text on the right margin, likely bleed-through from the reverse side of the page. The text is mostly illegible but appears to be a list or index of items.

12480

CERTIFICATE OF DEATH

12489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Darlington		c. LENGTH OF STAY IN lb 17 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stafford Road		e. STREET ADDRESS Stafford Road	
3. NAME OF DECEASED (Type or print) HAROLD S. KING		4. DATE OF DEATH Month September Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 5, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 24 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor of Chemistry		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Liverpool, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward S. King		14. MOTHER'S MAIDEN NAME Kate I. Colson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 408-34-2484A	
17. INFORMANT Mrs. Susan B. King, Darlington, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Certain Sclerosis DUE TO (c) 29ms		INTERVAL BETWEEN ONSET AND DEATH 11 MIN 50	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 11, 1967 , to Sept 17, 1967 , that (I) (we) last saw the deceased alive on Sept 16, 1967 , and that death occurred at 5:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Dudley Phillips		22b. DATE SIGNED 9/17/67	
22c. PHYSICIAN'S NAME (Type) Dudley Phillips MD		22d. ADDRESS DARLINGTON, Md 21034	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Sept. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY U. of Md. School of Medicine	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John H. Harbina		25a. REC'D BY REGISTRAR Delta, Penna.	
25b. REGISTRAR'S SIGNATURE SEP 21 1967		25c. REGISTRAR'S SIGNATURE John H. Harbina	

STATEMENT OF DEATH

U. S. 221

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

10/19/67

12481

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G392 9/11/67 pb

CERTIFICATE OF DEATH

12430

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>5</u> WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WARREN J. KNIGHT</u>		4. DATE OF DEATH <u>9-5-1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-99</u>
9. AGE (In years last birthday) <u>68</u> Yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilson KNIGHT</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Love</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-30-7412</u>	
17. INFORMANT <u>MRS. HAMILTON LITTLE, DARLINGTON, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Asevd</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition 2° to Ca of Cecum</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/31</u> , 19 <u>67</u> , to <u>9/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/3/67</u> , 19 <u>67</u> , and that death occurred at <u>8:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Gulest</u>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. GRIEDELIT</u>		22d. ADDRESS <u>MD. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, MD.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Gulest</u>			

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MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12482

12491

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pylesville			c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pylesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NANNIE B. LESTER				4. DATE OF DEATH Month Day Year Sept. 23, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 24, 1882	
9. AGE (In years last birthday) yrs. 85		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cedar Bluff, Va.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George Hankins			
14. MOTHER'S MAIDEN NAME Lottie Helbert				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Evetett Linkous, Pylseville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19, 1967</u>, to <u>Sept 23, 1967</u>, that (I) (we) last saw the deceased alive on <u>Sept 23, 1967</u>, and that death occurred at <u>4</u> PM, from causes and on the date stated above.							
22a. SIGNATURE Josiah A. Hunt				22b. DATE SIGNED Sept. 23, 1967		22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.	
22d. ADDRESS Delta, Pa.				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE John H. Harbina				22g. DATE SEP 27 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Fountain Green, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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12483

CERTIFICATE OF DEATH

12492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>52 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route #3, Plum Tree Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>John David Matherly</u>		4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Oct. 1888</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Std. Equip. Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Matherly (D)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John D. Matherly Jr. Bel Air, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorenal failure</u> DUE TO (b) <u>Chronic Cardiac Decompensation</u> DUE TO (c) <u>A.S.C.V.D. Class IV, D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>> 6 weeks</u> <u>3-4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca. of prostate to metastasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/16th, 1967</u> to <u>9/5, 1967</u> that (I) (we) lost saw the deceased alive on <u>9/5, 1967</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Hauce de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8 Sep. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Maryland</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Walter Macomber, Jr.</u>		25a. REC'D BY REGISTRAR <u>Tarring Funeral Home, Aberdeen, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 8 1967</u>	

12883

CERTIFICATE OF DEATH

DEATH OF A PERSON UNDER THE AGE OF 18 YEARS

Given at New York

12883

12883

12883

12883

12883

12883

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12493

12484

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>179 Parlington Ave</u>		d. STREET ADDRESS <u>179 Parlington Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Gerald McMahon</u>		4. DATE OF DEATH <u>September 1, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (Ret) Dept. of Army</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>Joseph McMahon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Ralph Rodney, Long Meadows Mass</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810 Embolus Liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer - M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-1-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Removal</u>		<u>2 Sep. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>St. Patricks Cemetery</u>		<u>Blakely, Penna</u>	
24. FUNERAL DIRECTOR <u>Tarring Funeral Home, Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

100

12485

CERTIFICATE OF DEATH

12494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAIR DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville 12.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>XXXXXX Route #1, Box 41</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Winfield</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Sep. 1876</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Bunce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-4362-A</u>	
17. INFORMANT <u>Mrs. Charles Ely, Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Asemic</u> DUE TO (b) <u>Extensive infiltrative Ca Prostate</u> DUE TO (c) <u>6 mps</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic elevated V Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>Sept 8, 1967</u> , and that death occurred at <u>12:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Ralph Horky</u>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky, M.D.</u>		22d. ADDRESS <u>Churchville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10 Sep. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Meth. Cemetery, Bel Air, Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Tarring Funeral Home, Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

IN RE: [Name]

Case No. [Number]

Filed [Date]

Plaintiff, [Name]

vs.

Defendant, [Name]

BY [Name], Attorney for Plaintiff

Subscribed and sworn to before me this [Date]

12486

CERTIFICATE OF DEATH

12495

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		d. STREET ADDRESS <u>RD 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Bernard Moran</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 March 1910</u>
9. AGE (In years, last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Occupational Health</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APG. U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rochester, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Technician Michael G. Moran (D)</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Moran (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW--II</u>		16. SOCIAL SECURITY NO. <u>293-01-7960</u>	
17. INFORMANT <u>Ruth W. Moran, Street, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>161X</u> IMMEDIATE CAUSE (a) <u>Confluent Bilateral Bronchopneumonia & Uremia</u> DUE TO (b) <u>Carcinoma Right epiglottic fold & cervical metastases</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>67</u> , to <u>9-14</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9-14</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes on and on the date stated above.			
22a. SIGNATURE <u>A. W. Grigoleit</u>		22b. DATE SIGNED <u>9/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. W. GRIGOLEIT</u>		22d. ADDRESS <u>HAYRE de GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>19 Sep. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Helstu Amcoubu Sr.</u>		25a. REC'D BY REGISTRAR <u>SEP 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. REGISTRAR'S NAME <u>James Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

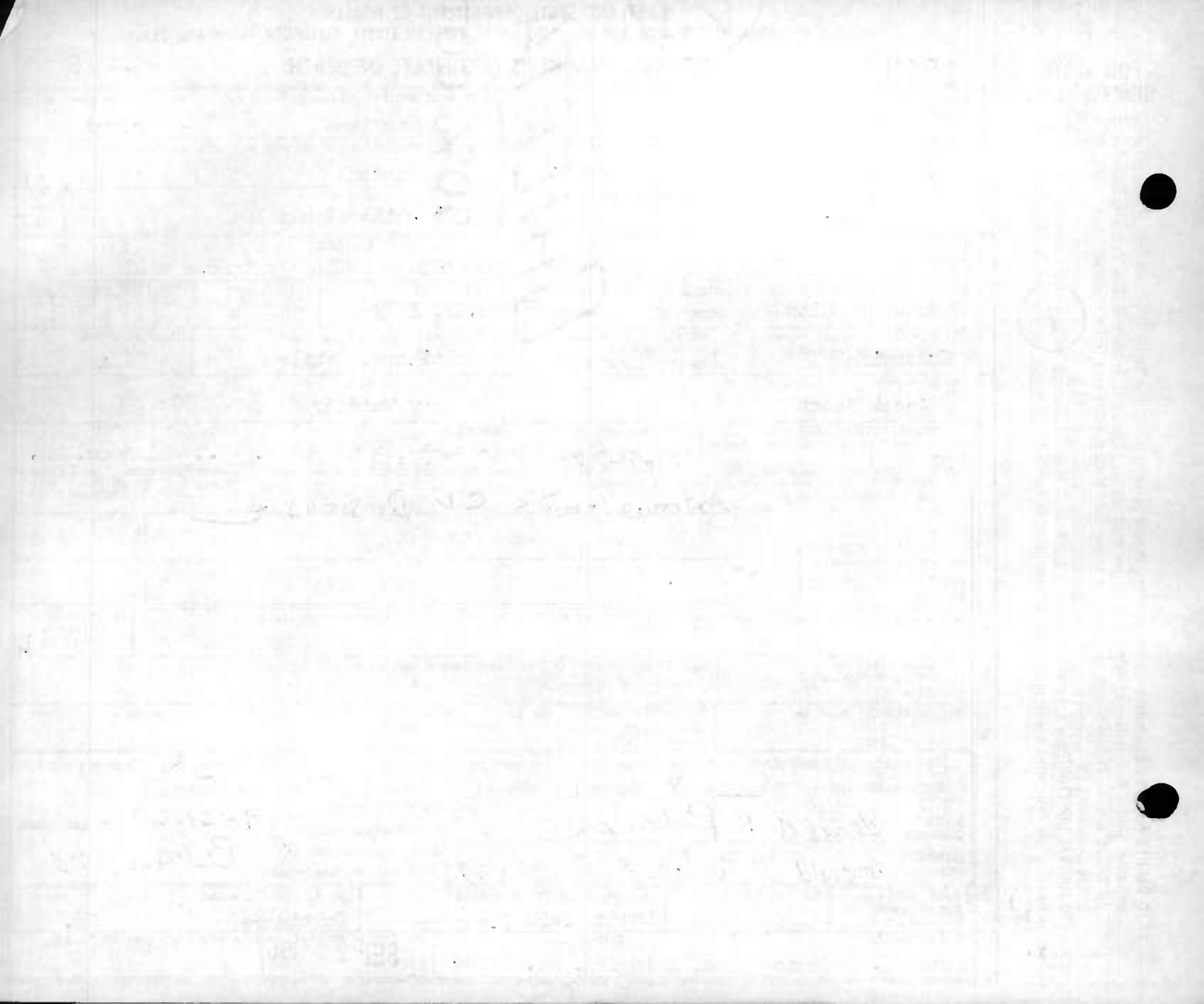
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12487

12496

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN lb 40 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS 3008 Philadelphia Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle WAIDNER Last MORKOSKY		4. DATE OF DEATH Month September Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1883
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Faust	
14. MOTHER'S MAIDEN NAME Mary Waidner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 218-54-0925		17. INFORMANT Huie Petty, 3000 Phila. Rd., Abingdon, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald P Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-21-67	
EXAMINER'S NAME (Type) Gerald P Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22. DATE SIGNED	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Belair, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/64

12488

CERTIFICATE OF DEATH

12497

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. # 2</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence J. Morris</u>		4. DATE OF DEATH <u>9 15 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>May 24, 1910</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Machinery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>York Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Morris</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Glackin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>008-05-7495</u>	
17. INFORMANT <u>Wife</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Extensive myocardial infarction</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/15, 1967</u> to <u>9/15, 1967</u> that (I) (we) last saw the deceased alive on <u>9/15, 1967</u> , and that death occurred at <u>3:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>9/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Man's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pylesville Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkins</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>	
ADDRESS <u>Delta, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12483

12498

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bel Air	
d. STREET ADDRESS (If not in hospital, give street address) (RFD#3, Box #416) Vale Road		d. STREET ADDRESS (RFD#3, Box #416) Vale Road	
3. NAME OF DECEASED (Type or print) William Howard Peters		4. DATE OF DEATH Month September Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 7, 1906
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Floyd, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Z. Peters		14. MOTHER'S MAIDEN NAME Ella Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-8948	
17. INFORMANT Mrs. Lillie M. Trusler		18. ADDRESS 716 Bel Air Rd. Bel Air, Md. 21014	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5400 IMMEDIATE CAUSE (a) Hemorrhage from peptic ulcer DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S SIGNATURE Gerald C. Palmer M.D.		22. DATE SIGNED Sept. 14, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harf. Co., Md. 21014	
24. FUNERAL DIRECTOR W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Joseph William Foster

Barford

Barford

Barford

Barford - 21st Ave
(Rt. 2, Box 210)
Barford

22 Years

Barford - 21st Ave
(Rt. 2, Box 210)
Barford

x

67

September 14,

Barford

Barford

Barford

Barford, 1906

Barford

U.S.A.

Barford, Virginia

Barford

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Barford
(Rt. 2, Box 210)

Barford

Barford, 1906
Barford, 1906

Barford, 1906

Barford

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x

Sept. 1, 1906

Barford, 1906

Barford, 1906

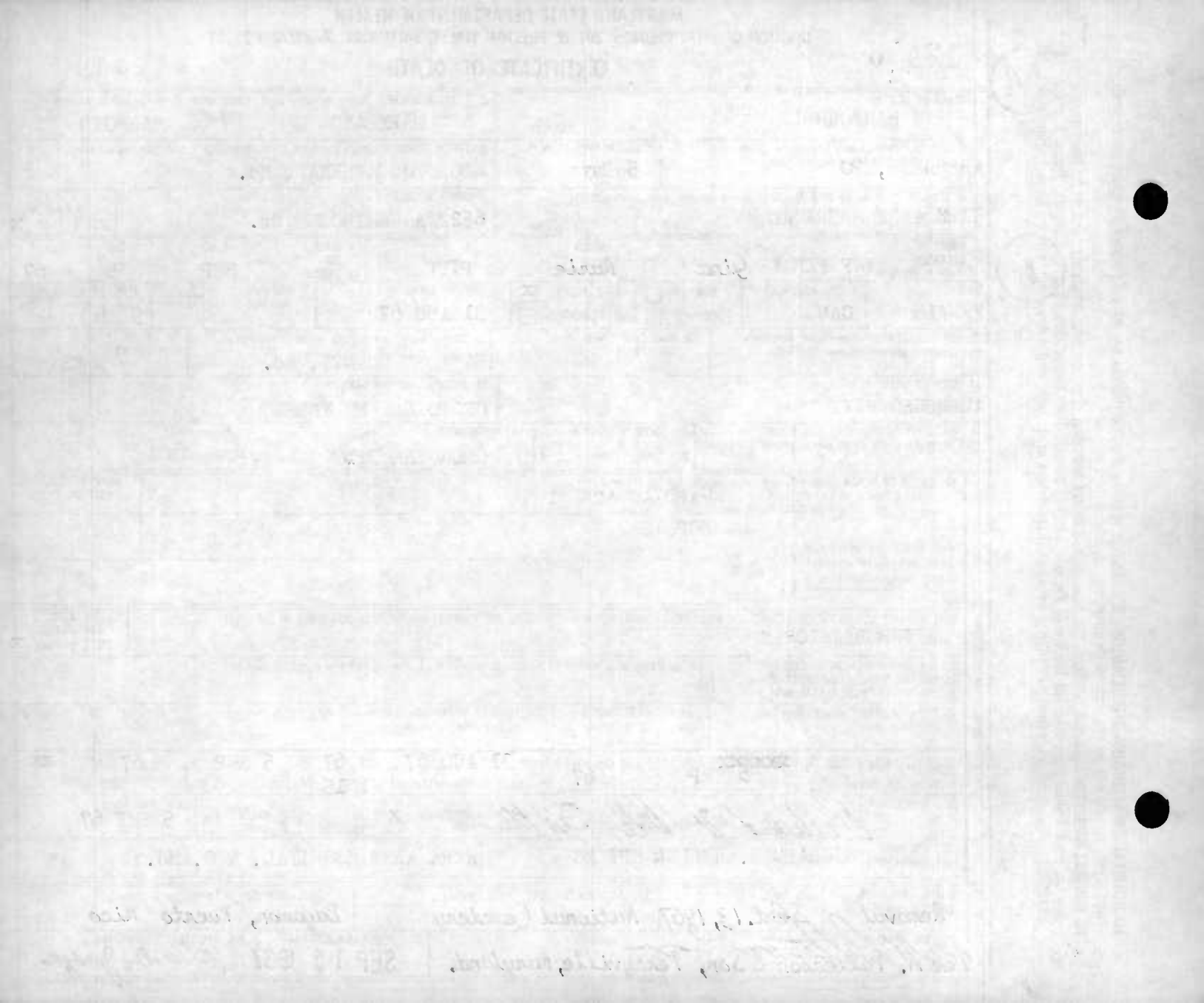
Barford

Barford, 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12490		CERTIFICATE OF DEATH	
12499			
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABEDDEN, MD		c. LENGTH OF STAY IN 1b 5 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWOOD ARSENAL, Md.		d. STREET ADDRESS 6522 A HAWTHORNE Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIRK ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last INF FEMALE Gina Marie PITT		4. DATE OF DEATH Month Day Year SEP 5 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 AUG 67
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months Days Hours Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HARFORD CO NTY, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALPHONSO PITT		14. MOTHER'S MAIDEN NAME GEORGINA MELENDEZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT GEORGINA PITT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7680 CARDIAC ARREST IMMEDIATE CAUSE (a) DUE TO SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ERYTHROBLASTOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 31 AUG 67 , 19 67 , to 5 SEP , 19 67 that (I) (we) saw the deceased alive on 5 SEP , 19 67 , and that death occurred at 1015 M , from causes and on the date stated above.			
22a. SIGNATURE <i>Richard H. Heller</i>		22b. DATE SIGNED 5 SEP 67	
22c. PHYSICIAN'S NAME (Type) RICHARD H. HELLER CPT MC		22d. ADDRESS KIRK ARMY HOSPITAL, APG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Sept. 13, 1967	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City or Town) (County) (State) Bayamon, Puerto Rico
24. FUNERAL DIRECTOR <i>Lee A. Patterson</i>		25a. REC'D BY REGISTRAR SEP 15 1967	
ADDRESS Lee A. Patterson & Son, Perryville, Maryland.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



12500

CERTIFICATE OF DEATH

12491

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL or end give nearest town) Havre de Grace		LENGTH OF STAY (in this place) DOA		CITY (If outside corporate limits, write RURAL and give nearest town) Fallston		RD 2 Box 332	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital				STREET ADDRESS (If rural give location) Engle Road		21047	
3. NAME OF DECEASED (Type or Print) FRANK (First) Herbert (Middle) PRESTON (Last)				4. DATE OF DEATH (Month) Sept (Day) 12 (Year) 1967			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 4, 1895		9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Harford County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry J. Preston				14. MOTHER'S MAIDEN NAME Sarah Jane Amberman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 218-18-2647		17. INFORMANT & ADDRESS Mrs. Annie A. Preston RD #2 Box 332 Fallston, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4431 IMMEDIATE CAUSE (A) Congestive Heart Failure						7 da.	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardiovas. Dis.						10 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9/8, 1967, to 9/12, 1967, that I last saw the deceased alive on 9/12, 1967, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE Edward J. Lucason M.D.				ADDRESS (Street, city, town, state) Fork Md		DATE SIGNED 9/12/67	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/16/1967		NAME OF CEMETERY OR CREMATORY Jarrettsville		LOCATION (City, town, or county) (State) Jarrettsville, Md.	
24. REC'D BY REGISTRAR SEP 14 1967		REGISTRAR'S SIGNATURE Charles E. Kurtz		25. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz		ADDRESS Jarrettsville, Md.	

21084

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1
The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Place of death (City, State, Country)

8. Cause of death (Print or write full name)

9. Signature of physician

10. Signature of registrar

11. Signature of witness

12. Signature of witness

13. Signature of witness

14. Signature of witness

15. Signature of witness

16. Signature of witness

17. Signature of witness

18. Signature of witness

19. Signature of witness

20. Signature of witness

21. Signature of witness

22. Signature of witness

23. Signature of witness

24. Signature of witness

25. Signature of witness

26. Signature of witness

27. Signature of witness

28. Signature of witness

29. Signature of witness

30. Signature of witness

31. Signature of witness

32. Signature of witness

33. Signature of witness

34. Signature of witness

35. Signature of witness

36. Signature of witness

37. Signature of witness

38. Signature of witness

39. Signature of witness

40. Signature of witness

41. Signature of witness

42. Signature of witness

43. Signature of witness

44. Signature of witness

45. Signature of witness

U.S. DEPARTMENT OF HEALTH - BALTAMORE, MD.

U.S. DEPARTMENT OF HEALTH - BALTAMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12492

CERTIFICATE OF DEATH

12501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delta</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>R.D.#1 Box 32</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilson Leroy Reynolds</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1914</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>Andrew Ellsworth Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Margie Hepps</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>313-16-4159</u>		17. INFORMANT Address <u>MRS. OLIVE M. REYNOLDS, DELTA, PA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemolytic Crisis</u> DUE TO <u>Acquired Hemolytic Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Acquired Hemolytic Anemia</u> (c) <u>Acquired Hemolytic Anemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-12, 1967</u> to <u>9-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-17, 1967</u> , and that death occurred at <u>4:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Leo, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Leo, M.D.</u>				22d. ADDRESS <u>Harre de Grace, Ind</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEP-21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. NEBO</u>		23d. LOCATION (City or town) (County) (State) <u>DELTA, YORK Co., PA.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12493

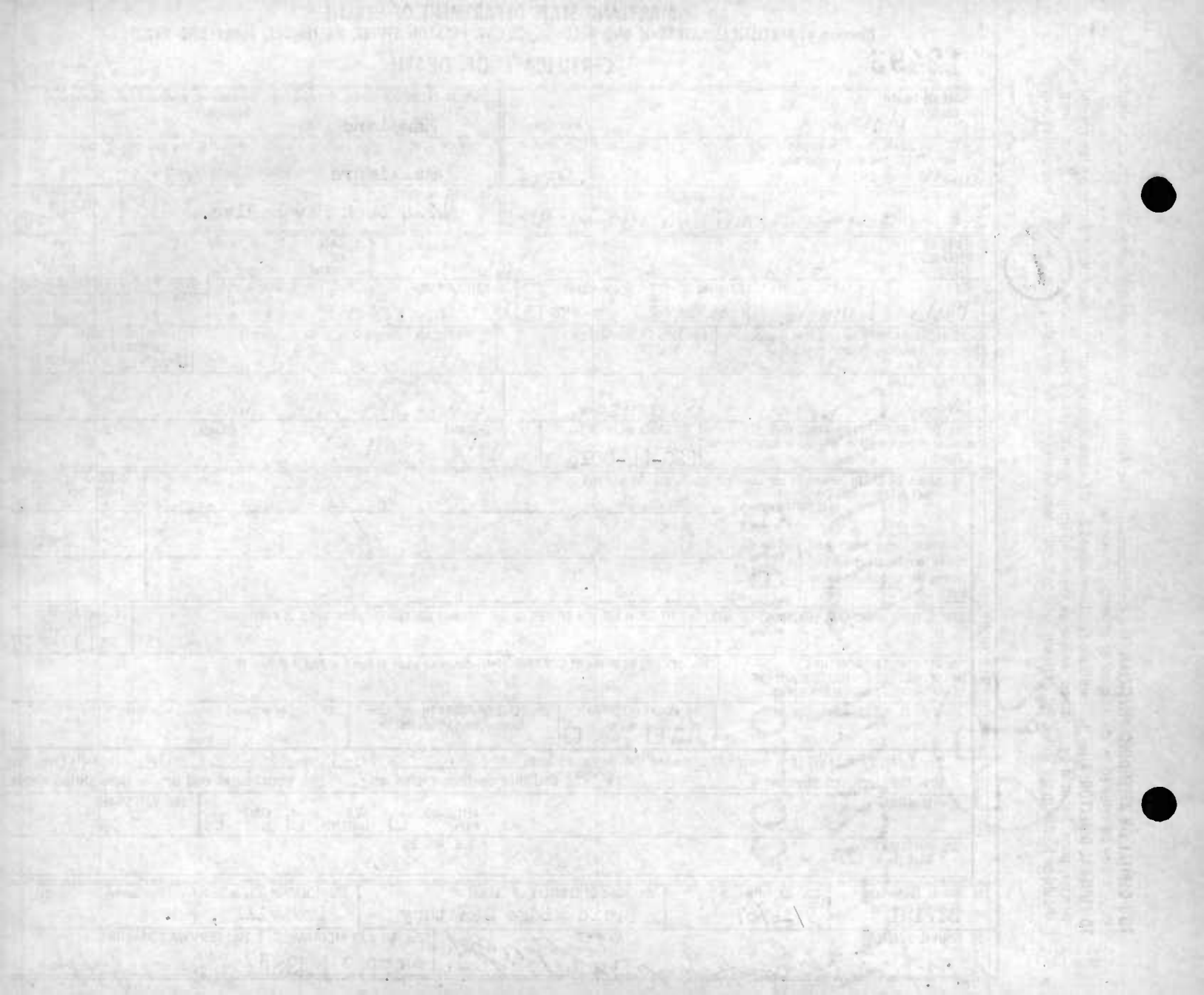
CERTIFICATE OF DEATH

12502

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN lb <u>2 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brevin Nursing Home 421 Union Ave.</u>		d. STREET ADDRESS <u>4224 Loch Raven Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry L Robinson</u>		4. DATE OF DEATH Month Day Year <u>9 13 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 7, 1880</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep. Comm. of Customs</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Charles Joshua Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Virginia Burch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-44-0018</u>	
17. INFORMANT <u>A. Canaw A. H.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation, Chronic</u> 4221 OUE TO (b) <u>A.S. C.V.D. Class IV, D</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u> <u>2-3 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/25, 1967</u> to <u>9/13, 1967</u> that (I) (we) last saw the deceased alive on <u>9/13, 1967</u> and that death occurred at <u>9:44 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>9/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tinkner Sons North Pa.</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

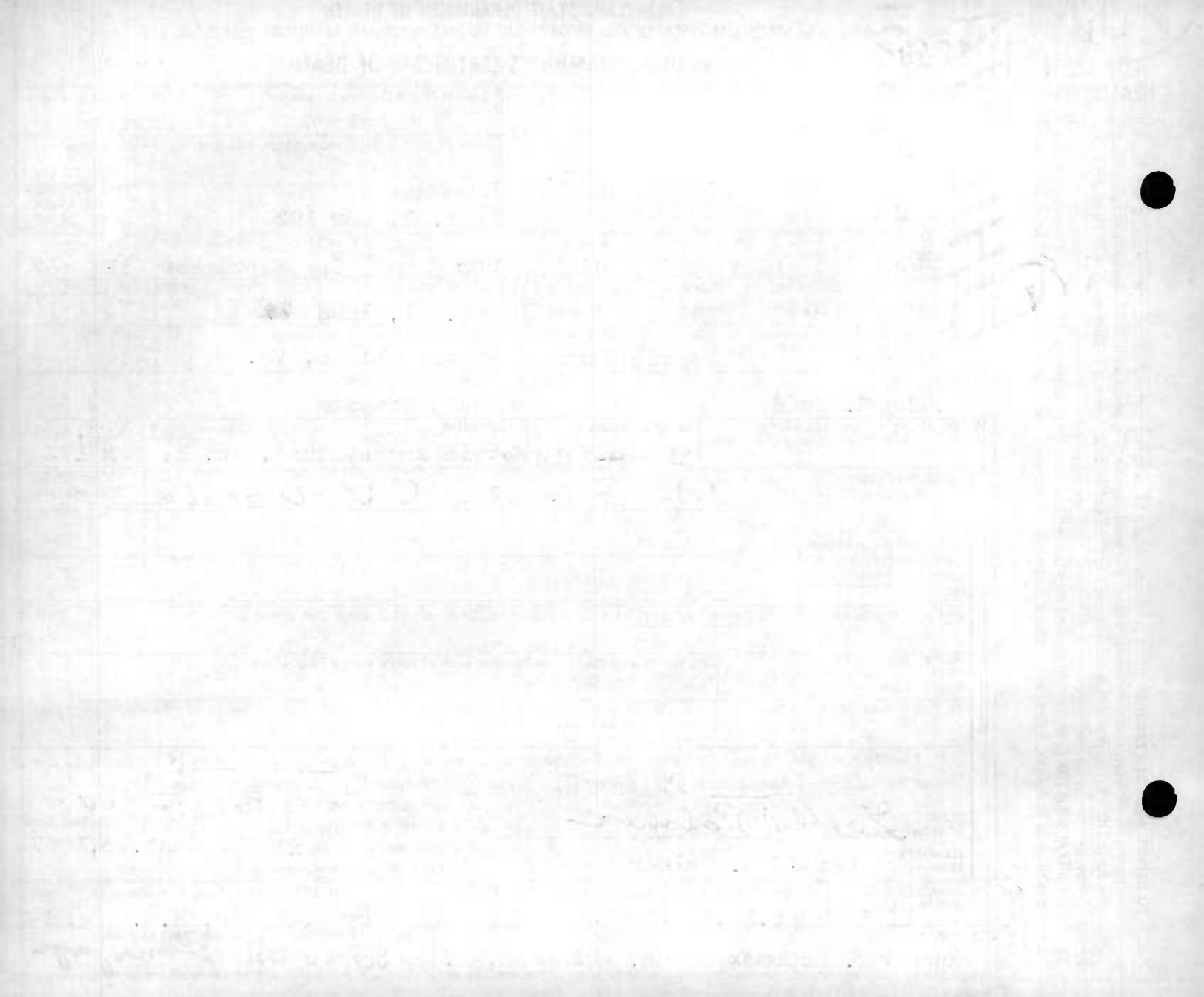


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12494		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						12503			
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none						d. STREET ADDRESS Rt. 1, Box 192				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LACY Middle VON Last RUDD						4. DATE OF DEATH Month September Day 12 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1888		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Tazewell Co, Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John R. Rudd						14. MOTHER'S MAIDEN NAME Ann Simpson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-40-1312		17. INFORMANT Mattie Rigsby Rudd, Rt. 1, Box 192 Address Bel Air, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C. Palmer				EXAMINER'S NAME (Type) Gerald C. Palmer				22. DATE SIGNED Sept. 13, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Welcome Home Cemetery			23d. LOCATION (City or Town) (County) (State) Bel Air, R.D. Md		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



12495

CERTIFICATE OF DEATH

12504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md. c. LENGTH OF STAY in lb 37 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home, Havre de Grace, Md.		d. STREET ADDRESS 515 Edmund St.	
3. NAME OF DECEASED (Type or print) First Annie Middle Alverta Last Scott		4. DATE OF DEATH Month Sept. Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-81
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		9b. KIND OF BUSINESS OR INDUSTRY Private Families	
10a. BIRTHPLACE (County & State, or foreign country) Perryman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (No Record) Tildon		14. MOTHER'S MAIDEN NAME Sarah Holland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-48-6910	
17. INFORMANT Mrs. Bertha J. Lilley, Havre de Grace, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart disease, Low Back Syndrome & Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 57 , to 9/15 , 19 67 , that (I) (we) last saw the deceased alive on 9/14 , 19 67 , and that death occurred at 2:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE George T. Stansbury		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 569 Revolution St. Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-67	23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem	23d. LOCATION (City or Town) (County) (State) Aberdeen Harford Co. Md.
24. FUNERAL DIRECTOR Charles J. Bullock, 5506 Lemm St. Hb. Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE SEP 25 1967	

12496

CERTIFICATE OF DEATH

12505

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>Rural - Port Deposit</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Stanley</i> Middle <i>S.</i> Last <i>Sentman Sr</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>1</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cau.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5, 1911</i>
9. AGE (In years last birthday) <i>56</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post Master</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis B. Sentman</i>		14. MOTHER'S MAIDEN NAME <i>Anna Barker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>Yes</i> <i>WW2</i>		16. SOCIAL SECURITY NO. <i>220-18-4068</i>	
17. INFORMANT <i>Alma A. Sentman, Port Deposit, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Ventricular Fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <i>Coronary thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 Min.</i> <i>1 hr 25 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>66</i> , to <i>Sept 1</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Sept 1</i> , 19 <i>67</i> , and that death occurred at <i>12 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>G. H. Richards Jr.</i>		22b. DATE SIGNED <i>9/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. H. Richards Jr. M.D.</i>		22d. ADDRESS <i>Port Deposit, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9-4-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Port Deposit, Md.</i>
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 6 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12497

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) JOSEPH O. STIKE		4. DATE OF DEATH Month September Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1945
9. AGE (In years lost birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.-Explosives	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Charles H. Stike	
14. MOTHER'S MAIDEN NAME Guyda L. Greer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-42-1682		17. INFORMANT Address Mrs. Joseph O. Stike, Cardiff, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of abdomen DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation	
20c. TIME OF INJURY Month, Day, Year Hour 9:30 p.m. 9 23 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern	20f. (City or town) (County) (State) Forest Hill Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i> EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED Sept. 26, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge	23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.
24. FUNERAL DIRECTOR <i>John H. Hawkins</i> Delta, Pennsylvania		25a. REC'D BY REGISTRAR DATE SEP 28 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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12498

CERTIFICATE OF DEATH

12507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>23 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Old York Road</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Edith</u> Last <u>Sutton</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6/28/1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years lost birthday) yrs. <u>81</u>
11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Howard Troyer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rebecca Melvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-56-3305</u>	
17. INFORMANT <u>Mrs. Edna Hodges</u>		<u>2026 W. Stella St. Philadelphia, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Quinidian fibrillation</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ABVD</u> DUE TO (c)		19132 INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Quemisia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/21, 1967</u> to <u>9/13, 1967</u> that (I) (we) last saw the deceased alive on <u>9-13</u> 19 <u>67</u> , and that death occurred at <u>1150</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A.W. Grigoleit</u>		22b. DATE SIGNED <u>9/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>		22d. ADDRESS <u>Harre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Monkton, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>Jarrettsville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 15 1967</u>	

CERTIFICATE OF DEATH

210

10-1-1932

Home

Residence

Alcoholic excess

John Robert Taylor

No

21-1-1932

Alcoholic excess

John

John

JOHN CRICKEY

John

John

John

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

4345R
10/19/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12495 CERTIFICATE OF DEATH 12508									
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Harford</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Fallston</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Fallston</i> 12-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <i>Rural</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>E.</i> Middle <i>Tom</i> Last <i>Tombaugh</i>					4. DATE OF DEATH <i>Sept. 11</i> 1967				
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 11 - 1882</i>		9. AGE (In years last birthday) <i>85</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Stark Co., Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Jacob Tombaugh</i>					14. MOTHER'S MAIDEN NAME <i>Clementine Nancy Brosserman</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>366-38-2465</i>		17. INFORMANT <i>Berlin Tombaugh</i>			Address <i>Fallston, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i> ??	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9/11/67</i> , 19, to <i>9/11</i> , 1967, that (I) (we) last saw the deceased alive on <i>9/11</i> , 1967, and that death occurred at <i>1145</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles Richardson Jr.</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/12/67</i>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <i>P.O. Box 488, Bel Air, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Sept 14, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Waugh Chapel</i>		23d. LOCATION (City, town or county) (State) <i>Glen Arm. Md</i>			
24. FUNERAL DIRECTOR <i>W. St. Archer</i>					ADDRESS <i>Benson Md</i>		25a. REC'D BY REGISTRAR <i>SEP 18 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>

1

The following is a list of the
 names of the persons who
 have been appointed to the
 various committees of the
 Board of Directors of the
 City of New York, for the
 year 1900.

The following is a list of the
 names of the persons who
 have been appointed to the
 various committees of the
 Board of Directors of the
 City of New York, for the
 year 1900.

12500

CERTIFICATE OF DEATH

12509

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 39 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS Rt 2, Box 113	
3. NAME OF DECEASED (Type or print) First CHARLES Middle PHILIP Last WEBSTER		4. DATE OF DEATH Month September Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1923
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (County & State, or foreign country) Oxford, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph I. Webster		14. MOTHER'S MAIDEN NAME Nan Poole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-12-8951	
17. INFORMANT Eugene H. Webster		Address Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-5- , 19 67 , to 9-13- , 19 67 , that (I) (we) last saw the deceased alive on 11-20- , 19 67 , and that death occurred at 4:35 PM , from causes and on the date stated above.			
22a. SIGNATURE Peter P. Rodman, M.D.		22b. DATE SIGNED 9-13-67	
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		22d. ADDRESS 8 Law St., Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION (City or town) (County) (State) Forest Hill Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR SEP 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

SS 101

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>		<p>9. Date of burial</p>	
<p>10. Name of physician</p>		<p>11. Name of funeral director</p>		<p>12. Name of undertaker</p>	
<p>13. Name of informant</p>		<p>14. Name of registrar</p>		<p>15. Name of registrar</p>	
<p>16. Name of registrar</p>		<p>17. Name of registrar</p>		<p>18. Name of registrar</p>	
<p>19. Name of registrar</p>		<p>20. Name of registrar</p>		<p>21. Name of registrar</p>	
<p>22. Name of registrar</p>		<p>23. Name of registrar</p>		<p>24. Name of registrar</p>	
<p>25. Name of registrar</p>		<p>26. Name of registrar</p>		<p>27. Name of registrar</p>	
<p>28. Name of registrar</p>		<p>29. Name of registrar</p>		<p>30. Name of registrar</p>	
<p>31. Name of registrar</p>		<p>32. Name of registrar</p>		<p>33. Name of registrar</p>	
<p>34. Name of registrar</p>		<p>35. Name of registrar</p>		<p>36. Name of registrar</p>	
<p>37. Name of registrar</p>		<p>38. Name of registrar</p>		<p>39. Name of registrar</p>	
<p>40. Name of registrar</p>		<p>41. Name of registrar</p>		<p>42. Name of registrar</p>	
<p>43. Name of registrar</p>		<p>44. Name of registrar</p>		<p>45. Name of registrar</p>	
<p>46. Name of registrar</p>		<p>47. Name of registrar</p>		<p>48. Name of registrar</p>	
<p>49. Name of registrar</p>		<p>50. Name of registrar</p>		<p>51. Name of registrar</p>	
<p>52. Name of registrar</p>		<p>53. Name of registrar</p>		<p>54. Name of registrar</p>	
<p>55. Name of registrar</p>		<p>56. Name of registrar</p>		<p>57. Name of registrar</p>	
<p>58. Name of registrar</p>		<p>59. Name of registrar</p>		<p>60. Name of registrar</p>	
<p>61. Name of registrar</p>		<p>62. Name of registrar</p>		<p>63. Name of registrar</p>	
<p>64. Name of registrar</p>		<p>65. Name of registrar</p>		<p>66. Name of registrar</p>	
<p>67. Name of registrar</p>		<p>68. Name of registrar</p>		<p>69. Name of registrar</p>	
<p>70. Name of registrar</p>		<p>71. Name of registrar</p>		<p>72. Name of registrar</p>	
<p>73. Name of registrar</p>		<p>74. Name of registrar</p>		<p>75. Name of registrar</p>	
<p>76. Name of registrar</p>		<p>77. Name of registrar</p>		<p>78. Name of registrar</p>	
<p>79. Name of registrar</p>		<p>80. Name of registrar</p>		<p>81. Name of registrar</p>	
<p>82. Name of registrar</p>		<p>83. Name of registrar</p>		<p>84. Name of registrar</p>	
<p>85. Name of registrar</p>		<p>86. Name of registrar</p>		<p>87. Name of registrar</p>	
<p>88. Name of registrar</p>		<p>89. Name of registrar</p>		<p>90. Name of registrar</p>	
<p>91. Name of registrar</p>		<p>92. Name of registrar</p>		<p>93. Name of registrar</p>	
<p>94. Name of registrar</p>		<p>95. Name of registrar</p>		<p>96. Name of registrar</p>	
<p>97. Name of registrar</p>		<p>98. Name of registrar</p>		<p>99. Name of registrar</p>	
<p>100. Name of registrar</p>		<p>101. Name of registrar</p>		<p>102. Name of registrar</p>	

1

THE STATE OF NEW YORK, COUNTY OF ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12501					12510				
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u> <u>12.1</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>719 Girard Street</u>					d. STREET ADDRESS <u>719 Girard St.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Henry Webster</u>					4. DATE OF DEATH Month Day Year <u>Sept. 28, 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1904</u>		9. AGE (in years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Webster</u>					14. MOTHER'S MAIDEN NAME <u>Martha L. Bond</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-28-0180HA</u>		17. INFORMANT <u>Mr. John A. Webster, 719 Girard St. Harrode Grace, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-28-1967</u> to <u>9-28-1967</u> , that (I) (we) last saw the deceased alive on <u>9-28-1967</u> , and that death occurred at <u>6:10</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward J. Simon</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>					22d. ADDRESS <u>Harrode Grace</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Harlington, Harford Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Elmer Bulluck</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
ADDRESS <u>556 South St. Harrode Grace, Md.</u>					DATE <u>OCT 4 1967</u>				

STATE DEPARTMENT OF HEALTH BUREAU OF STATISTICAL RECORDS AND REPORTS CERTIFICATE OF DEATH

1930

10-10-30

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of birth: <i>Jan 15 1885</i></p>	
<p>5. Place of birth: <i>City of New York</i></p>	
<p>6. Usual residence: <i>123 Main St, New York City</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>	
<p>8. Date of death: <i>Oct 10 1930</i></p>	
<p>9. Time of death: <i>10:30 AM</i></p>	
<p>10. Place of death: <i>Home</i></p>	
<p>11. Signature of physician: <i>Dr. J. Smith</i></p>	
<p>12. Signature of registrar: <i>John Doe</i></p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BUREAU OF STATISTICAL RECORDS AND REPORTS, AND IN THE OFFICE OF THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12511

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Churchville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Churchville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Aldino Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WAYNE Middle WOODRUFF Last WOODRUFF		4. DATE OF DEATH Month Sept. Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6 April 1926
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 4 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Commercial Steel, Ashe Co., N.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Woodruff (D)		14. MOTHER'S MAIDEN NAME Annie Osborne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Raymond V. Woodruff, Churchville, Md.	
17. INFORMANT Raymond V. Woodruff, Churchville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to CO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9731 (c) 9731 DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Piped exhaust fumes into his truck			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Piped exhaust fumes into his truck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Sept. 4 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Churchville, Aberdeen Harford Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Sept. 4, 1967 DATE SIGNED	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Bel Air, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 Sep. 67	
23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aberdeen, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Tarring Funeral Home		25a. REC'D BY REGISTRAR SEP 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

35-12

Commercial Importation

Patent Rights

April 1900

Commercial Importation

Patent

Patent Rights

Commercial Importation

Patent Rights

Patent Rights

Patent Rights

Patent Rights

Patent Rights

Patent Rights

Patent Rights

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12503

12512

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHITEFORD (RURAL)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHITEFORD (RURAL)	
c. LENGTH OF STAY IN b 24 YRS.		d. STREET ADDRESS DAVIS FARM RT 136 2 MILES WEST	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DAVIS FARM RT 136 2 miles west		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EARL CARL YORK		4. DATE OF DEATH Month Day Year SEPT 30 1967	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1926
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days 41	
11. IF UNDER 24 HRS. Hours Min. 41		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM HAND		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) KINGSVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES F. YORK		14. MOTHER'S MAIDEN NAME HANNAH C. BURK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-1646	
17. INFORMANT Address MRS. EARL YORK, WHITEFORD, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN HEMORRHAGE - CONCUSSION 8124 DUE TO (b) STRUCK BY AUTOMOBILE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) STEPPED IN FRONT OF AUTOMOBILE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. SEPT 30 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT 136		20f. (City or town) (County) (State) WHITEFORD, HARFORD, MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Heuman		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 307 HICKORY ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> BELAIR, SEPT 30, 1967 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MARYLAND Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 3, 1967	
22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or country) (State) DELTA, YORK CO., PA.	
23. FUNERAL DIRECTOR John H. Harkins, DELTA, PA.		24a. REC'D BY REGISTRAR OCT 5 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge		24c. REGISTRAR'S SIGNATURE	

